MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Allied Health • Durable Medical Equipment and Medical Supplies

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Contents

Spinal Osteogenic Bone Growth Stimulator Benefits Added

Effective for dates of service on or after September 1, 2006, noninvasive electrical osteogenesis stimulator for spinal application HCPCS code E0748 will be a Medi-Cal benefit, subject to prior authorization. Pursuant to *Welfare and Institutions Code*, Section 14105.48, the purchase reimbursement rate for code E0748 has been established at $3,030.73.

The coverage policies for osteogenic stimulators, E0747 (electrical non-spinal), E0748 (electrical spinal), and E0760 (ultrasound) have been updated as follows:

- A dated order for the osteogenesis stimulator and related supply items, signed by the treating physician, must be kept on file by the supplier of the equipment.
- All claims for an osteogenesis stimulator and related supplies must include an ICD-9 code that describes the condition requiring the device. For nonunion fractures, the claim must include both the ICD-9 code 733.82 (nonunion of fracture) and the specific ICD-9 code for the fracture site.

Non-Spinal, Electrical Osteogenesis Stimulator

Non-spinal electrical osteogenesis stimulator devices are billed with HCPCS code E0747 and are covered for nonunion fractures only if the following criteria are met:

- Nonunion of a long bone fracture, defined as radiographic evidence that fracture healing has ceased.
- Six months or more have passed since the fracture.
- Bone X-rays over the last three months show no sign of continued healing.
- Six months or more have passed since the alternative treatment was initiated.
- The fracture gap is one centimeter or less.
- The patient can be adequately immobilized and is able to comply with non-weight bearing.
- For infantile (congenital) pseudoarthroses (ICD-9 code 755.8).
- There is evidence of skeletal maturity or the patient is 20 years of age or older.

Note: Nonunion of the long bone must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and including a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of films.

A non-spinal electrical osteogenesis stimulator will be denied as not medically necessary if none of the above criteria are met.

Please see **Bone Growth**, *page 2*

Spinal, Electrical Osteogenesis Stimulator

Spinal electrical osteogenesis stimulator devices are billed with HCPCS code E0748 and are covered only if any of the following applies:

- Failed spinal fusion (pseudoarthrosis-ICD-9 code V45.4, joint following fusion) and a minimum of nine months have elapsed since the last surgery, or
- Following a multi-level spinal fusion surgery, involving three or more vertebrae (for example, L3-5, L4-S1, etc.), or
- Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site, or
- The patient has one or more risk factors for high risk of spinal fusion failure such as: smoking, obesity (BMI > 35), diabetes, renal disease, alcoholism, grade II or worse Spondylolisthesis, or other metabolic disease where bone healing is poor.

Note: The device should be applied within 30 days as an adjunct to spinal fusion surgery. The patient should use the device for at least two hours per day and the treatment period continued for nine months (270 consecutive days). The device is programmed to cease operation at the end of 270 days.

Non-Invasive, Low Intensity Ultrasound Treatment

Non-invasive, low intensity ultrasound osteogenesis devices are billed with HCPCS code E0760 and are reimbursable at a "per treatment" rate only if the following criteria are met:

- Nonunion of a fracture other than the skull or vertebrae in a skeletally mature person, documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days each, including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs; and
- The fracture is not tumor-related.
- Fresh (< 7days), closed or grade I open, tibial diaphyseal fractures; or
- Fresh (< 7days), closed fractures of the distal radius (Colles fracture).

Note: An ultrasonic osteogenesis stimulator will be denied as not medically necessary if the criteria above are not met. An ultrasonic osteogenesis stimulator may not be used concurrently with other noninvasive stimulators.

Reimbursement

The purchase-only reimbursement is all-inclusive of the following:

- All accessories necessary to use the unit (for example, electrodes, wires, gel, cables, etc.)
- Patient education on the proper use and care of the equipment
- Routine servicing and all necessary repairs or replacement to make the unit functional

This information is reflected on manual replacement pages dura bil dme 12 thru 15 (Part 2), dura cd 24 (Part 2) and tax 6 and 7 (Part 2).

Online Survey for the Medical Supply UPN Pilot

The California Department of Health Services (CDHS) is asking providers to complete an online survey for the Medical Supply Universal Product Number (UPN) Pilot.

This survey is to solicit and assess the level of provider interest in the pilot. Enrollment in the pilot is anticipated to begin later this year. To access the survey, visit the UPN area of the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking the "UPN" link under "Provider Resources." The survey link is available in the "UPN Resources" box in the upper right-hand side of the page. This survey will be available to providers until September 15, 2006.

Some of the advantages of participating in the pilot include:

- Online real-time claims processing, which allows for immediate claim status notification
- No requirement to submit pricing attachments
- Improved speed and accuracy of claim payments

Providers can e-mail questions and comments regarding the pilot to CDHS through the "Medi-Cal Comment Forum" page, which can also be accessed through the UPN area of the Medi-Cal Web site. The forum has been extended past the closing date of July 31, 2006 and **will remain open until further notice**. The responses to questions and comments will be used to update the "Frequently Asked Questions" page, which can also be accessed through the UPN area of the Medi-Cal Web site.

Background

The Health Insurance Portability and Accountability Act (HIPAA) mandates the use of HCPCS Level II codes on electronic medical supply claims. As a result, CDHS plans to discontinue all interim medical supply codes and convert to HCPCS Level II codes. Due to the generic nature of the HCPCS Level II codes, CDHS requested, and was granted, an exception to the HIPAA standards by the Centers for Medicare & Medicaid Services (CMS). The exception allows for the use of the UPN as part of a two-year pilot for billing and payment of medical supplies within the following four product categories:

1. Urinary catheters and bags (urologicals)
2. Incontinence supplies
3. Ostomy care products
4. Wound care products

2007 ICD-9 Diagnosis Code Update

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after October 1, 2006. Providers may refer to the *2007 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptors.

Additions

The following ICD-9 diagnosis codes are new:

052.2	053.14	054.74	238.71	238.72	238.73	238.74
238.75	238.76	238.79	277.30	277.31	277.39	284.01
284.09	284.1	284.2	288.00	288.01	288.02	288.03
288.04	288.09	288.4	288.50	288.51	288.59	288.60
288.61	288.62	288.63	288.64	288.65	288.69	289.53
289.83	323.01	323.02	323.41	323.42	323.51	323.52
323.61	323.62	323.63	323.71	323.72	323.81	323.82
331.83	333.71	333.72	333.79	333.85	333.94	338.0
338.11	338.12	338.18	338.19	338.21	338.22	338.28
338.29	338.3	338.4	341.20	341.21	341.22	377.43
379.60	379.61	379.62	379.63	389.15	389.16	429.83
478.11	478.19	518.7	519.11	519.19	521.81	521.89
523.00	523.01	523.10	523.11	523.30	523.31	523.32

Please see **ICD-9 Codes**, *page 4*

ICD-9 Codes *(continued)*

523.33	523.40	523.41	523.42	525.60	525.61	525.62
525.63	525.64	525.65	525.66	525.67	525.69	526.61
526.62	526.63	526.69	528.00	528.01	528.02	528.09
538	608.20 *	608.21 *	608.22 *	608.23 *	608.24 *	616.81 **
616.89 **	618.84 **	629.29 **	629.81 ** +	629.89 **	649.00 ** +	649.01 ** +
649.02 ** +	649.03 ** +	649.04 ** +	649.10 ** +	649.11 ** +	649.12 ** +	649.13 ** +
649.14 ** +	649.20 ** +	649.21 ** +	649.22 ** +	649.23 ** +	649.24 ** +	649.30 ** +
649.31 ** +	649.32 ** +	649.33 ** +	649.34 ** +	649.40 ** +	649.41 ** +	649.42 ** +
649.43 ** +	649.44 ** +	649.50 ** +	649.51 ** +	649.53 ** +	649.60 ** +	649.61 ** +
649.62 ** +	649.63 ** +	649.64 ** +	729.71	729.72	729.73	729.79
731.3	768.70 #	770.87 #	770.88 #	775.81 #	775.89 #	779.85 #
780.32	780.96	780.97	784.91	784.99	788.64	788.65
793.91	793.99	795.06 **	795.81	795.82	795.89	958.90
958.91	958.92	958.93	958.99	995.20	995.21	995.22
995.23	995.27	995.29	V18.51	V18.59	V26.34 *	V26.35 *
V26.39 *	V45.86	V58.30	V58.31	V58.32	V72.11	V72.19
V82.71	V82.79	V85.51	V85.52	V85.53	V85.54	V86.0 ** +
V86.1 ** +						

Restrictions

* Restricted to males only
** Restricted to females only
\# Restricted to ages 0 thru 1 year
\+ Restricted to ages 10 thru 99

Inactive Codes

Effective for dates of service on or after October 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

238.7, 277.3, 284.0, 288.0, 323.0, 323.4, 323.5, 323.6, 323.7, 323.8, 333.7, 478.1, 519.1, 521.8, 523.0, 523.1, 523.3, 523.4, 528.0, 608.2, 616.8, 629.8, 775.8, 784.9, 793.9, 995.2, V18.5, V58.3, V72.1

Code Description Revisions

The descriptions of the following ICD-9 diagnosis codes are revised:

255.10, 285.29, 323.1, 323.2, 323.9, 333.6, 345.40, 345.41, 345.50, 345.51, 345.80, 345.81, 389.11, 389.12, 389.14, 389.18, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 524.21, 524.22, 524.23, 524.35, 600.00, 600.01, 600.20, 600.21, 600.90, 600.91, 780.31, 780.95, 790.93, 873.63, 873.73, 995.91, 995.92, 995.93, 995.94, V26.31, V26.32

Manual replacement pages reflecting these ICD-9 code updates will be included in a future *Medi-Cal Update.*

Replacement of Power Wheelchair Interfaces Using Modifier -KC

Providers are reminded that modifier -KC (replacement of special power wheelchair interface) should be used only for the replacement of a power wheelchair interface (HCPCS codes E2320 – E2322 and E2327) due to the following situations:

- A change in the patient's condition
- When both the interface and the controller electronics are being replaced due to irreparable damage

Please see **Power Wheelchairs**, *page 5*

Power Wheelchairs *(continued)*

Modifier -KC with codes E2320 – E2322 or E2327 may not be used at the time of initial issue of a wheelchair and will not be separately reimbursed if billed in the same month of service with power wheelchair base codes E1239, K0010, K0011, K0012 or K0014 billed with modifier -NU.

Claims for the replacement of these special interface codes E2320 – E2322 or E2327 must be billed with modifiers -RP/-NU/-KC (for a patient-owned power wheelchair) or -RR/-KC (for a power wheelchair rental). The modifiers must be entered on the claim in that specific order. Reimbursement for the replacement of a power wheelchair interface for a patient-owned power wheelchair (as identified by the use of modifiers -RP/-NU/-KC, with documentation regarding the specific power wheelchair, and that it is owned by the patient) does not include the cost of labor. Providers may bill code E1340 to be separately reimbursed for labor. Code E1340 is not separately reimbursable for the replacement of power wheelchair interface on a rental power wheelchair (modifiers -RR/-KC).

Reminder: Provider do not enter hyphens or other punctuation on the claim. Modifiers are entered on the claim without a preceding hyphen.

The updated information is reflected on manual replacement pages dura bil dme 4 and 5 (Part 2).

Waterproof Sheeting Update Affecting Acquisition Cost, Transition Period and Quantity Limit

Effective for dates of service on or after August 1, 2006, providers can purchase waterproof sheeting from the contracted manufacturers listed below using the new Maximum Acquisition Cost (MAC). Reimbursement to providers based on the new MAC price is effective for dates of service beginning October 1, 2006.

For dates of service on or before September 30, 2006, providers may bill both contracted products and non-contracted products. When billing using code 9947A TI or 9947A VS in that time period, providers are reimbursed according to the pricing in effect prior to June 1, 2006 or on the basis of a catalog page or invoice.

Effective for dates of service on or after October 1, 2006, all manufacturers' products not included in a contract will no longer be a Med-Cal benefit, will not be granted prior authorization or a *Treatment Authorization Request* (TAR) and will not be reimbursed.

The quantity limitation of three (3) in a 365-day period, that would have taken effect on September 1, 2006, has been rescinded. Quantity limitations for waterproof sheeting will continue at a maximum of two (2) in a 365-day period, per recipient, unless approved through prior authorization.

Manufacturer	Description	Stock Number	UPC	MAC	Billing Code
G. Hirsch & Company Inc.					
	Poly/Vinyl Quilted, with Anchor band, 39" x 75"	SR 832	000891832001	$22.00	9947A TI
	Cooltex with Bactishield, 36" x 72"	SR 837	000891837006	$22.00	9947A TI
Humanicare International, Inc.					
	Sheeting, Waterproof, Quilted rubber free hypoallergenic 36" x 80"	36080	(01)00044156360809	$22.00	9947A VS
	Sheeting, Waterproof, Quilted rubber free hypoallergenic 39" x 75"	39075	(01)00044156390752	$22.00	9947A VS

These updates are reflected on manual replacement page mc sup lst3 14 (Part 2).

'By Report' Wheelchair Reimbursement Modified

Effective for dates of service on or after September 1, 2006, wheelchairs, wheelchair accessories and replacement parts billed "By Report" will be reimbursed the least of:

- Amount billed pursuant to *California Code of Regulations* (CCR), Title 22, Section 51008.1, or
- The manufacturer's purchase invoice amount, plus a 67 percent markup, or
- The Manufacturer's Suggested Retail Price (MSRP), as follows:
  - 80 percent of MSRP, or
  - 85 percent of MSRP if the provider employs or contracts with a qualified rehabilitation professional as defined in *Welfare and Institutions Code* 14105.485, which is documented on the claim.

This reimbursement methodology replaces the previous tier method of reimbursing wheelchairs, accessories and replacement parts based on a total aggregate MSRP.

The updated information is reflected on manual replacement page dura bil dme 7 (Part 2).

MSRP Documentation Date Change for 'By Report' DME

Durable Medical Equipment (DME) providers billing for items reimbursed "By Report" were previously required to submit documentation with their claims including Manufacturers' Suggested Retail Price (MSRP) published prior to August 1, 2003. Effective for dates of service on or after September 1, 2006, changes in *Welfare and Institutions Code* (W&I Code), Section 14105.48, revised the published date of MSRP documentation to be prior to June 1, 2006.

The MSRP may be documented with a hard copy catalog page or a hard copy of an electronic catalog page.

This information is reflected on manual replacement pages dura 7 (Part 2), dura bil dme 8 and 10 thru 12 (Part 2), dura bil inf 5 (Part 2), dura bil oxy 10 (Part 2) and dura ex 12 and 14 thru 18 (Part 2).

2006 CPT-4/HCPCS Updates: Implementation November 1, 2006

The 2006 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2006. The affected codes are listed below. Only those codes representing current or future Medi-Cal benefits are included. Please refer to the 2006 CPT-4 and HCPCS Level II code books for complete descriptions of these codes. Specific policy, billing information and manual replacement pages reflecting these changes will be released in a future *Medi-Cal Update.*

HCPCS Level II Code Additions

Durable Medical Equipment and Supplies
A4604, A9281, E0170, E0171, E0641, E0642, E0705, E0911, E0912, E1392, E2207 – E2215, E2218 – E2226, E2371, E2372, K0734 – K0737

Orthotic Procedures and Devices
L0491, L0492, L0621 – L0640, L0859, L2034, L2387, L3671 – L3673, L3702, L3763 – L3766, L3905, L3913, L3919, L3921, L3933, L3935, L3961, L3967, L3971, L3973, L3975 – L3978

Prosthetic Procedures and Appliances
A6513, A6542, A6544, L5703, L5858, L5971, L6621, L6677, L6883 – L6885, L7400 – L7405

Please see **CPT-4/HCPCS**, *page 7*

CPT-4/HCPCS *(continued)*

HCPCS Level II Codes with Description Changes

Durable Medical Equipment and Supplies
A4632, A6550, A7032, A7033, A8033, E0240, E0463, E0464, E0637, E0638, E0935, E0971, E1038, E1039, K0669

Orthotic Procedures and Devices
L1832, L1843 – L1846, L2036 – L2038, L2405, L3215 – L3217, L3219, L3221, L3222, L3230, L3906, L3923, L8010

HCPCS Level II Code Deletions

Durable Medical Equipment
A6551, E0972, E1019, E1021, E1025 – E1027, K0064, K0066 – K0068, K0074 – K0076, K0078, K0102, K0104, K0106, K0452

Orthotic Procedures and Devices
K0619, K0630 – K0649, L0860, L1750, L2039, L3963

Prosthetic Procedures and Appliances
L8210, L8230

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Remove and replace:	dura 7/8
Remove:	dura bil dme 3 thru 22
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* Pages updated due to ongoing provider manual revisions.